SERFF Tracking Number:	*LLNS-126392182*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*44147*
Company Tracking Number:	*WSD-EAPP*		
TOI:	*H11I Individual Health - Disability Income*	*Sub-TOI:*	*H11I.006 Short Term - Related to marketing with employer or association groups*
Product Name:	*Workplace Short Term Disabiilty Application*		
Project Name/Number:	*WSD-EAPP/WSD-EAPP*		

Filing at a Glance

Company: Illinois Mutual Life Insurance Company

Product Name: Workplace Short Term Disabiilty Application	SERFF Tr Num: LLNS-126392182	State: Arkansas
TOI: H11I Individual Health - Disability Income	SERFF Status: Closed-Approved-Closed	State Tr Num: 44147
Sub-TOI: H11I.006 Short Term - Related to marketing with employer or association groups	Co Tr Num: WSD-EAPP	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Hollie Henderson	Disposition Date: 12/01/2009
	Date Submitted: 11/20/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: WSD-EAPP	Status of Filing in Domicile: Pending
Project Number: WSD-EAPP	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 12/01/2009	Explanation for Other Group Market Type:
	State Status Changed: 12/01/2009
Deemer Date:	Created By: Hollie Henderson
Submitted By: Hollie Henderson	Corresponding Filing Tracking Number:

Filing Description:

Referenced forms are submitted for your review and approval. These forms are in final print.

Application Form WSD-EAPP is an application used with Short Term Disability Policy Form WSD07, which was approved by your department on 12/21/06 under SERFF Filing # LLNS-125064095 .

Application Form WSD-EAPP will be used in addition to Application Form WSD-APP07, which was approved by your

SERFF Tracking Number:	*LLNS-126392182*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*44147*
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Product Name:	*Workplace Short Term Disabiilty Application*		
Project Name/Number:	*WSD-EAPP/WSD-EAPP*		

department on 12/21/06 under SERFF Filing # LLNS-125064095 . Application Form WSD-APP07 is to be used for paper enrollments where an agent is present to assist and receive the application. Application Form WSD-EAPP is to be used for web-based enrollments where the applicant is completing the application online and there is no agent present. The only difference between WSD-EAPP and previously approved WSD-APP07 is that the agent certification statement has been removed from Form WSD-EAPP and replaced with a statement that this is an electronic application completed without the presence or assistance of an agent. Form WSD-APP07 is attached to this filing as reference with the Agent Certification red lined to indicate the removal.

Illinois Mutual, working alone, and/or with a licensed insurance agent, will provide applicants with the ability to apply for our insurance products via a web-browser-based software application. Access to this web-browser-based software application will be communicated, and/or made available, to the applicants in a variety of forms and distribution mediums, including, but not limited to, one or more web-based Universal Resource Locator (URL) addresses and/or hyperlinked content (text, images, etc.).

Employees will be notified by their employer of the availability of an short term disability insurance policy and will be directed to a secure website where they can make application. The application process will be done electronically including an electronic signature of the applicant. The completed application will be submitted to Illinois Mutual electronically using appropriate encryption standards.

A copy of the application is attached to the policy at the time the policy is issued and delivered to the policyholder.

Thank you in advance for your assistance in reviewing this filing.

Company and Contact

Filing Contact Information

Hollie Henderson, Executive and Legal Coordinator	hghenderson@illinoismutual.com	
300 SW Adams Street	309-674-8255 [Phone] 436 [Ext]	
Peoria, IL 61634	309-674-2076 [FAX]	

Filing Company Information

Illinois Mutual Life Insurance Company	CoCode: 64580	State of Domicile: Illinois
300 SW Adams Street	Group Code: -99	Company Type:
Peoria, IL 61634	Group Name:	State ID Number:
(309) 674-8255 ext. [Phone]	FEIN Number: 37-0344290	

SERFF Tracking Number:	*LLNS-126392182*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*44147*
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Product Name:	*Workplace Short Term Disabiilty Application*		
Project Name/Number:	*WSD-EAPP/WSD-EAPP*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	50/form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Illinois Mutual Life Insurance Company	$50.00	11/20/2009	32205525

SERFF Tracking Number:	*LLNS-126392182*	*State:*	*Arkansas*
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Product Name:	*Workplace Short Term Disabiilty Application*		
Project Name/Number:	*WSD-EAPP/WSD-EAPP*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/01/2009	12/01/2009

SERFF Tracking Number:	*LLNS-126392182*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*44147*
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Product Name:	*Workplace Short Term Disabiilty Application*		
Project Name/Number:	*WSD-EAPP/WSD-EAPP*		

Disposition

Disposition Date: 12/01/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LLNS-126392182*	*State:*	*Arkansas*
Filing Company:	*Illinois Mutual Life Insurance Company*	*State Tracking Number:*	*44147*
Company Tracking Number:	*WSD-EAPP*		
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Project Name/Number:	*WSD-EAPP/WSD-EAPP*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	WSD-APP07	Approved-Closed	Yes
Form	Workplace Short Term Disability Application	Approved-Closed	Yes

SERFF Tracking Number:	*LLNS-126392182*	*State:*	*Arkansas*
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Product Name:	*Workplace Short Term Disabiilty Application*		
Project Name/Number:	*WSD-EAPP/WSD-EAPP*		

Form Schedule

Lead Form Number: WSD-EAPP

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/01/2009	WSD-EAPP	Application/ Enrollment Form	Workplace Short Term Disability Application	Initial		50.145	WSD_EAPP.pdf

☐ ESP

ILLINOIS MUTUAL®
Life Insurance Company

300 S.W. Adams Street Peoria, IL 61634
800.437.7355

Application for Workplace Voluntary Disability Income Insurance

1. Employee Information (Complete All)

a. Name _____ _____ _____ _____ _____ _____
LAST FIRST MI MAIDEN/FORMER MARITAL STATUS SEX

b. Address _____
STREET CITY STATE ZIP CODE

c. Home Ph. (_____) _____ **d.** E-mail Address _____

e. Soc. Sec. #_____ **f.** Date of Birth _____ **g.** State of Birth _____

h. Employer's Name _____

i. Date of Employment _____ **j.** Are you actively at work? ☐ Yes ☐ No **k.** Employee/Payroll # _____

l. Occupation _____

m. Hours worked per week _____ **n.** Monthly Salary $ _____ (excluding bonuses and overtime)

2. Policy Information (Complete All)

a. Industry Class _____ **b.** Elimination Period for Accident _____ Days **c.** Elimination Period for Sickness _____ Days

d. Benefit Period for Accident and Sickness _____ Months

e. Coverage Selected:

	Monthly Benefit	Weekly Premium
☐ Sickness and Off-Job Accident	$_____	$_____
☐ On-Job Accident	$_____	$_____

f. Payroll Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other_____

TOTAL PAYROLL PREMIUM DEDUCTED: $_____

g. Will coverage applied for replace or modify any disability insurance? ☐ Yes ☐ No If "Yes," please list

Company	Policy No.
_____	_____
_____	_____

h. Do you have any group or individual disability income insurance? ☐ Yes ☐ No If "yes", give details

Insurance Company	Monthly Benefit	Elimination/Benefit Period
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Modified Issue (To be completed with Sections 1 and 2)

a. Have you tested positive for exposure to the Human Immunodeficiency Virus (HIV), been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or other sickness or condition derived from such infection? ..... ☐ Yes ☐ No

b. In the past 12 months, other than colds, flu or normal pregnancy, have you taken time off from work or taken vacation for 5 or more consecutive days due to an injury, sickness, back, neck, knee, shoulder, joints, or muscular disorder?..... ☐ Yes ☐ No

c. In the past 12 months, have you received medical advice, sought treatment, including medication, or been hospitalized for any of the following? ..... ☐ Yes ☐ No

- Heart Attack/Heart Surgery
- Congestive Heart Failure
- Stroke/Transient Ischemic Attack (TIA)
- High Blood Pressure treated with 3 or more Medications
- Insulin Dependent Diabetes
- Cancer (except basal cell skin cancer)
- Hepatitis B or C
- Cirrhosis
- Kidney Disease (except stones)

4. Simplified Issue (To be completed with Sections 1, 2 and 3)

a. Height _____ Weight _____

b. In the past 5 years, have you received medical advice or sought treatment, including medication, for any of the following? ..... ☐ Yes ☐ No

- Heart Attack/Heart Surgery
- Congestive Heart Failure
- Stroke/Transient Ischemic Attack (TIA)
- Cancer (except basal cell skin cancer)
- End Stage Renal/Kidney Disease
- Chronic Obstructive Pulmonary Disease/Emphysema
- Liver Disease/Hepatitis B or C/Cirrhosis
- Neurological Disorder/Multiple Sclerosis
- Chronic Fatigue Syndrome
- Fibromyalgia

c. If the past 5 years, have you received medical advice or sought treatment, including medication, for any of the following?..... ☐ Yes ☐ No
If "yes", give full details below.

- Disease or disorder of the back, neck, knees, joints, muscles
- Carpal Tunnel Syndrome
- Diabetes
- Blood Pressure Reading of 140/90 or above

d. In the past 5 years, have you had any medical advice, diagnostic test, hospitalization, or physical exam that indicated a sickness or injury not listed above? ..... ☐ Yes ☐ No
If "yes", give full details below.

e. Are you currently taking any prescription medication? ..... ☐ Yes ☐ No
If "yes", give full details below.

f. Give details to all "Yes" answers c. thru e.

Question #	Sickness, Injury or Other	Date	Details, Length of Disability and Degree of Recovery	Complete Name of Physician, Hospital or Clinic and Current Address

Agreement

I represent and agree that: (1) all statements and information found in the application are deemed representations and not warranties; (2) all statements and answers herein are true and correctly recorded to the best of my knowledge and belief; (3) this application will be a part of any contract issued; (4) no policy issued on this application shall be effective until the 1st day of the month in which payroll deductions or authorized check deductions begin; and (5) I have received a Medical Information Bureau Notice.

Authorization: I hereby authorize my employer, Medical Information Bureau, Inc., or any consumer reporting agency who possesses information on me, to furnish such information to Illinois Mutual Life Insurance Company, hereinafter called the Company, or its legal representative upon presenting this Authorization or a photocopy. The Company or its authorized representatives may obtain information, in order to evaluate my application for insurance.

I have read this Authorization and understand that I may receive a copy upon request. I understand and agree that this Authorization shall be valid for two years from the date signed below.

I understand that this is an electronic application that has been completed and signed by me without the presence or assistance of an agent. I verify that the unique identifier used to sign this application is mine and that by clicking the "Submit" button; I am signing the application electronically. I hereby authorize my employer to deduct the premiums for this policy from my paycheck.

Notice: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signed at _____ _____

CITY AND STATE SIGNATURE OF EMPLOYEE

Date _____

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Project Name/Number:	*WSD-EAPP/WSD-EAPP*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	12/01/2009
Comments:			
Attachment:			
Readability.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	12/01/2009
Bypass Reason:	Being submitted for approval. See Forms Tab		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	12/01/2009
Bypass Reason:	Not Applicable. Submitting Application only		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	12/01/2009
Bypass Reason:	Not Applicable. Submitting Application only		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	WSD-APP07	Approved-Closed	12/01/2009
Comments:			
Attachment:			
WSD_APP07.pdf			

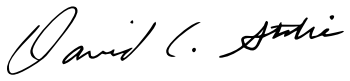
CERTIFICATION

Re: Form WSD-EAPP, Workplace Short Term Disability Application

On behalf of Illinois Mutual Life Insurance Company, I hereby certify that we have carefully analyzed and scored the forms submitted with this certification in accord with the Flesch score analysis readability procedures and we certify that the forms have a Flesch score as follows:

Form WSD-EAPP (Scored with Policy) 50.145

ILLINOIS MUTUAL LIFE INSURANCE COMPANY

By: 

David C. Storlie
Vice President
General Counsel

Dated: November 20, 2009

ILLINOIS MUTUAL®
Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634
Phone 309.674.8255

Application for Voluntary Disability Income Insurance

1. Employee Information (Complete All)

a. Name _____ _____ _____ _____ _____ _____
LAST FIRST MI MAIDEN/FORMER MARITAL STATUS SEX

b. Address _____ _____ _____ _____
STREET CITY STATE ZIP CODE

c. Home Ph. (_____) _____ **d.** E-mail Address _____

e. Soc. Sec. # _____ **f.** Date of Birth _____ **g.** State of Birth _____

h. Employer's Name _____

i. Date of Employment _____ **j.** Are you actively at work? ☐ Yes ☐ No **k.** Employee/Payroll # _____

l. Occupation _____

m. Hours worked per week _____ **n.** Monthly Salary $ _____ (excluding bonuses and overtime)

2. Policy Information (Complete All)

a. Industry Class _____ **b.** Elimination Period for Accident _____ Days **c.** Elimination Period for Sickness _____ Days

d. Benefit Period for Accident and Sickness _____ Months

e. Coverage Selected:

	Monthly Benefit	Weekly Premium
☐ Sickness and Off-Job Accident	$_____	$_____
☐ On-Job Accident	$_____	$_____

f. Payroll Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

TOTAL PAYROLL PREMIUM DEDUCTED: $_____

g. Will coverage applied for replace or modify any disability insurance? ☐ Yes ☐ No If "Yes," please list

Company	Policy No.
_____	_____
_____	_____

h. Do you have any group (excluding employer paid) or individual disability income insurance? ☐ Yes ☐ No If "yes", give details

Insurance Company	Monthly Benefit	Elimination/Benefit Period
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Modified Issue (To be completed with Sections 1 and 2)

a. Have you tested positive for exposure to the Human Immunodeficiency Virus (HIV), been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or other sickness or condition derived from such infection? ..... ☐ Yes ☐ No

b. In the past 12 months, other than colds, flu or normal pregnancy, have you taken time off from work or taken vacation for 5 or more consecutive days due to an injury, sickness, back, neck, knee, shoulder, joints, or muscular disorder? ..... ☐ Yes ☐ No

c. In the past 12 months, have you received medical advice, sought treatment, including medication, or been hospitalized for any of the following? ..... ☐ Yes ☐ No

- Heart Attack/Heart Surgery
- Congestive Heart Failure
- Stroke/Transient Ischemic Attack (TIA)
- High Blood Pressure treated with 3 or more Medications
- Insulin Dependent Diabetes
- Cancer (except basal cell skin cancer)
- Hepatitis B or C
- Cirrhosis
- Kidney Disease (except stones)

4. Simplified Issue (To be completed with Sections 1, 2 and 3)

a. Height _____ Weight _____

b. In the past 5 years, have you received medical advice or sought treatment, including medication, for any of the following? ..... ☐ Yes ☐ No

- Heart Attack/Heart Surgery
- Congestive Heart Failure
- Stroke/Transient Ischemic Attack (TIA)
- Cancer (except basal cell skin cancer)
- End Stage Renal/Kidney Disease
- Chronic Obstructive Pulmonary Disease/Emphysema
- Liver Disease/Hepatitis B or C/Cirrhosis
- Neurological Disorder/Multiple Sclerosis
- Chronic Fatigue Syndrome
- Fibromyalgia

c. If the past 5 years, have you received medical advice or sought treatment, including medication, for any of the following? ..... ☐ Yes ☐ No
If "yes", give full details below.

- Disease or disorder of the back, neck, knees, joints, muscles
- Carpal Tunnel Syndrome
- Diabetes
- Blood Pressure Reading of 140/90 or above

d. In the past 5 years, have you had any medical advice, diagnostic test, hospitalization, or physical exam that indicated a sickness or injury not listed above? ..... ☐ Yes ☐ No
If "yes", give full details below.

e. Are you currently taking any prescription medication? ..... ☐ Yes ☐ No
If "yes", give full details below.

f. Give details to all "Yes" answers c. thru e.

Question #	Sickness, Injury or Other	Date	Details, Length of Disability and Degree of Recovery	Complete Name of Physician, Hospital or Clinic and Current Address

Agreement

I represent and agree that: (1) all statements and information found in the application are deemed representations and not warranties; (2) all statements and answers herein are true and correctly recorded to the best of my knowledge and belief; (3) this application will be a part of any contract issued; (4) no policy issued on this application shall be effective until the 1st day of the month in which payroll deductions begin; and (5) I have received a Medical Information Bureau Notice.

Authorization: I hereby authorize my employer, Medical Information Bureau, Inc., or any consumer reporting agency, who posses information on me to furnish such information to Illinois Mutual Life Insurance Company, hereinafter called the Company, or its legal representative upon presenting this Authorization or a photocopy. The Company or its authorized representatives may obtain information, in order to evaluate my application for insurance.

I have read this Authorization and understand that I may receive a copy upon request. I understand and agree that this Authorization shall be valid for two years from the date signed below.

Signed at _____ _____

CITY AND STATE — SIGNATURE OF EMPLOYEE

Date _____

Notice: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

~~**Agent's Certification**~~

~~I certify that I asked the above questions of the Employee in person and have recorded the information correctly. An Outline of Coverage was given to the Applicant. I ☐ do ☐ do not have knowledge that the insurance applied for will replace any existing disability income insurance.~~

_____ _____

~~PRINT WRITING AGENT NAME~~ — ~~AGENT'S SIGNATURE~~

~~Agent's Code #~~ _____ ~~Agent's Phone #~~ _____